MONTANA
TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE
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HELENA MT 59620-0139
406 444-3134

TRS Office Use Only

AGREEMENT FOR ELECTRONIC FUNDS TRANSFER
AUTOMATED CLEARING HOUSE DEBIT AUTHORIZATION

ALL REQUESTED INFORMATION MUST BE TYPED OR PRINTED LEGIBLY IN DARK INK.

_____
(Employer's Printed Name)

_____
(Employer's Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code))

_____
(Montana Teachers' Retirement System Six-Digit Employer Number)

The employer hereby authorizes the Montana Teachers' Retirement System (TRS) to collect payments for employee and employer contributions due to the TRS by Electronic Funds Transfer (EFT) Automated Clearing House Debit (ACH Debit). The employer certifies that they have selected the following depository financial institution and directs that all such EFTs be made as provided below.

_____ _____
(Depository Financial Institution's Name) (Area Code and Telephone Number)

_____
(Depository Financial Institution's Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code))

_____ _____
(Depository Financial Institution's Transit Routing Number) (Account Number for ACH Debit)

_____ Indicate type of account
(Account Holder's Federal Tax ID Number) ☐ Checking ☐ Savings

_____ _____
(Employer's EFT Contact Person) (Area Code and Telephone Number)

_____
(Employer's EFT Contact Person's E-Mail Address)

The TRS will transfer funds from the employer's account to the State of Montana within five calendar days from the date the wages and contribution report is submitted. The transfer of funds represents the amount owed to the TRS as stated by the employer on the wages and contribution report.

The employer will give written notice ten days in advance to the TRS of any changes in the depository financial institution information or to request other payment arrangements.

When properly executed, this agreement will become effective within ten days after receipt by the TRS.

_____ _____
(Certifying Officer's Printed Name) (Title)

_____ _____
(Certifying Officer's Signature) **(Date)**

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST.